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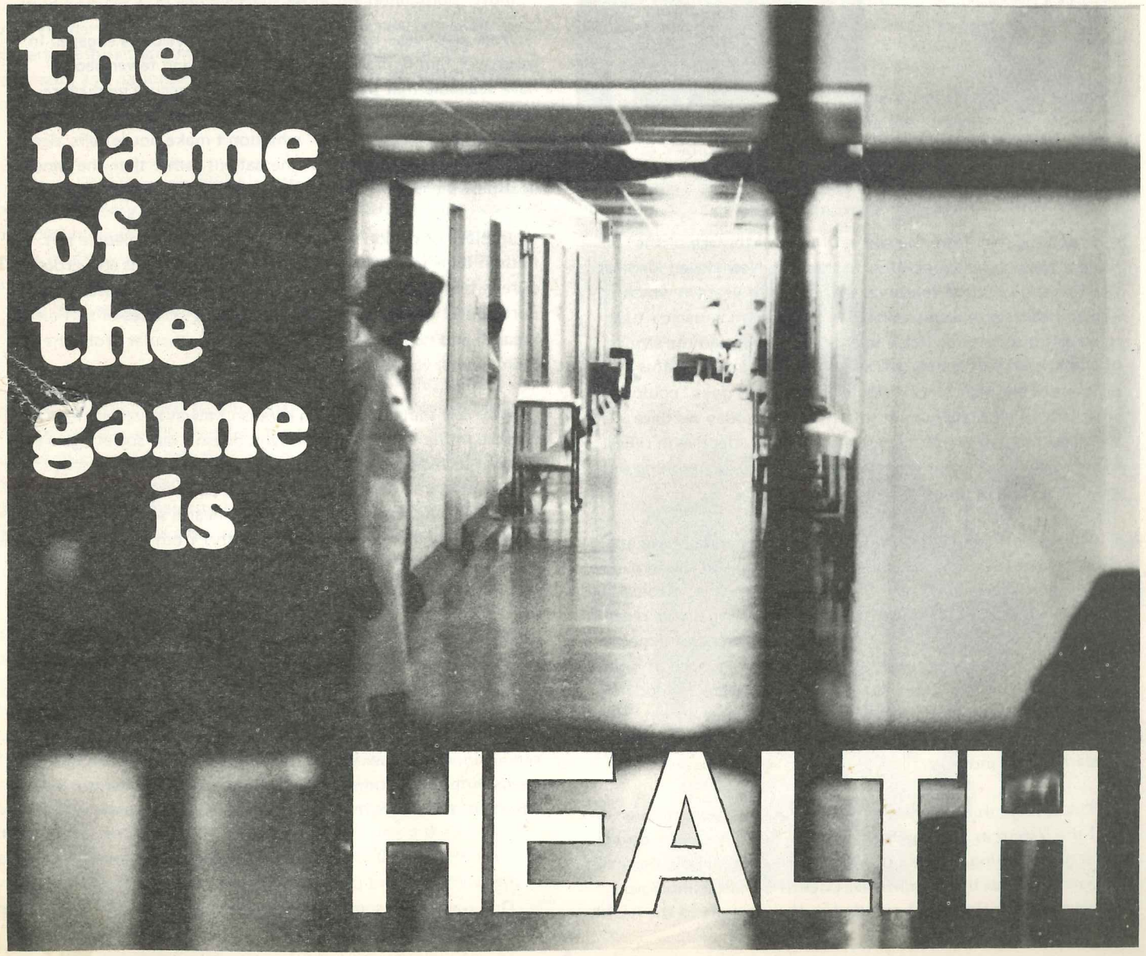
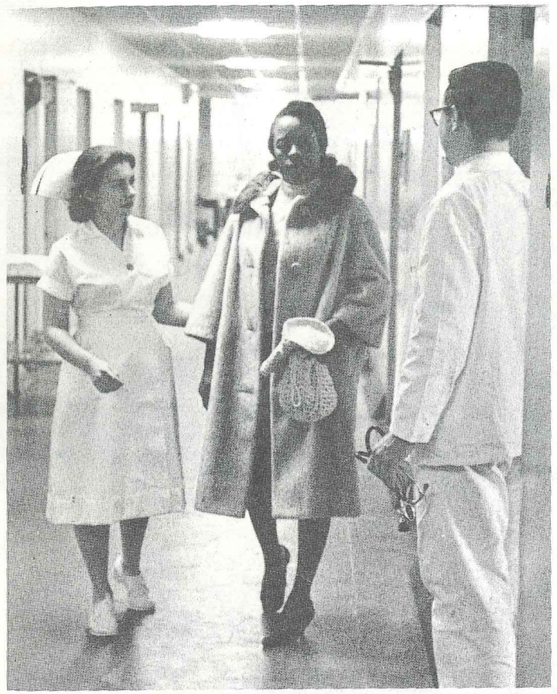
special issue

by Richard Katzman

The Yale New Haven Medical Center





I. The Marketplace

It's a long way from the island of Cos, birthplace of the ancient physician Hippocrates, to the Yale-New Haven Medical Center: thousands of miles, and hundreds of years in which human health care seems to have changed from a magic ritual to an art to something like a science. Not long ago the service of a physician was merely a luxury, a symbol of the status and privilege of the rich, since a doctor in the "old days" could do very little to alleviate human suffering. But today we have the sense that the art or science of healing is effective in relieving our pain, curing our illnesses, and, perhaps, postponing our inevitable confrontation with death.

The doctors and nurses who take care of us today have at their disposal all of the awesome, complex tools of modern science and technology; and from them spring the "medical miracles" such as human heart transplantation which we regard with a mixture of awe, gratitude and foreboding. Our expectations about health care have changed with the advance of modern medicine. No longer a luxury, it is now a necessity in modern society. No longer a privilege of the rich, it is now a right. People more and more are demanding access to the benefits of the modern health industry.

The strange thing in this country and in this town, though, is that the resources and capabilities of the health industry don't seem to be serving people's needs primarily. Somehow those resources and all those impressive scientific and technological achievements seem more harnessed to the interests of the health professions themselves than to the needs of the people in the society which they serve.

When someone needs health care, he becomes a consumer in a system which is at least as frustrating and perplexing as it is therapeutic. Only experts and professionals themselves are presumed to understand all of its complexities and intricacies. The consumer works his way through the modern health care labyrinth until he finds some relief or runs out of resources for paying what seem to be exorbitant fees for service. Nor does he have any way to hold accountable those who provide service to him, except in instances of flagrant, extreme malpractice; in fact, his society has conditioned him to trust in the sacred authority of the doctor, who is, after all, trained specifically to deal with matters of life and death.

For those in the economic position to take advantage of it there is, of course, the hopeful assumption that money buys quality. Poor people have no such leverage concerning their and their children's health; nor do those people in our country who make up the growing class of "medical indigents," able to meet regular living expenses but lacking the cash or insurance resources to cover all of their medical costs.

Year after year, as the percentage of physicians engaged in general or family practice declines, fewer and fewer people have available that traditionally longterm, secure medical resource—their "doctor." He is being replaced by the "specialist" and the "hospital resident," who don't make house calls, deal only with certain diseases of the patient rather than the general health of the person, and cost plenty.

In place of personal trust in these physicians, people put faith in their technology, the machines, tests, pills and procedures which they command. Those who have the means try to purchase what they hope will be specialty services of sufficient breadth and quality to cover both their particular problems and their general well-being.

Why is it that good health care isn't always available and accessible in the United States? Why doesn't our society guarantee that its massive health resources be deployed rationally and equitably to serve the needs of its people? The nation spent $53 billion last year for various health serviecs ($265 per person, more than in any other country) from an "industry" employing about three million individuals, including 280,000 active physicians.

But the fact is that the United States ranks below most other industrialized western countries on indices of national health such as life expectancy and infant and maternal mortality. Who is responsible—the government, the providers of health care, the consumers? Are those who control the American health service industry cloaking their failure to meet society's health needs in the very complexity of the services and institutions they run, and in the mythology of their sacred trust?

A Rational System

One way to get some insight into what is wrong with health care in this country is to consider for a moment the outline of a rational "health system." The two groups of people involved are, simply, the *consumer community* and the *"professional" providers*. They get together through an *organized system* of facilities, institutions and organizations which are set up to make optimal use of the society's resources for (1) providing care; (2) paying its costs; (3) training and educating future "professional" providers; and (4) conducting research to improve health care quality through "scientific" advance, in that order.

The organized system is designed to meet the consumer community's needs for service and the "professional" providers' needs for undertaking that service. The rational way in which such a balance is achieved is by making the planning and coordination of the organized system responsive strictly to the health needs of the people of the society.

There are a number of important things following from this little outline. First of all, it says that a rational modern health care system has to be organized systematically, and that the principle around which the organization develops must be the needs of the people. Thus: everyone must have access to a primary health care facility, and these facilities must be set down in keeping with the distribution of the population; from these primary units an individual must have access to health centers, hospitals and major medical centers based locally, regionally and nationally to provide care when his health problems become more severe and difficult to treat.

The cost of these services (whether obtained from the neighborhood primary unit or the major medical center) must not be a consideration if the individual is to have real confidence in the health system. The organized system must utilize the monetary resources of government to pay for the people's health care, as part of the "social security" for which they are taxed.

Secondly, the outline implies that the training and utilization of manpower in a good health system must also be organized in accordance with the needs of the society. Thus: if, as is the case in this country, less than one out of five workers in the health field is a physician, it is essential that the skills and talents of the vast majority of the industry's manpower be utilized fully, not just as aides to the physicians but as integrated components of the "health team," serving society.

The proportion of people trained for service versus research must reflect the needs and priorities of the people, not just the professionals. There must be real opportunities for continuing training and advancement among all health workers, so that potential skills are developed and productivity maximized.

Thirdly, the outline of a rational health system suggests that planning and coordination based on social needs is the key to successful organization. Thus: the people, the consumer community, must be involved; and control must fall to the total community, not just the professionals. This means that the people of the society oversee the organization of their health services, and the "professional" providers learn to understand and to serve them.

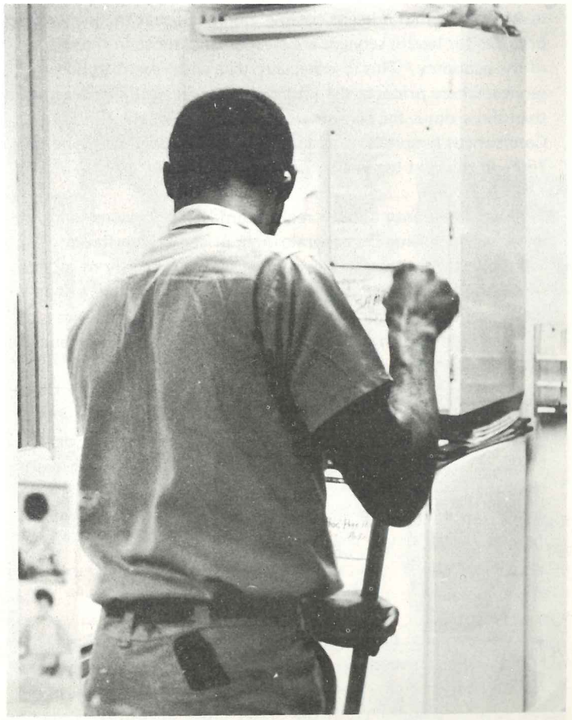
No Planning

The point is that the health service industry in the United States lacks virtually all of the features of a rational health system. There is no systematic organizaion of services, no disciplined distribution of the present supply of private doctors, group practices, clinics, community health centers, general hospitals, medical centers, nursing homes, visiting nurses, public health services, or voluntary agencies.

Health careers are controlled by professional and technical associations operating along the lines of medieval guilds, by the demands of the research industry and by academic institutions. Rigid lines of class and power separate doctors, nurses, technicians, and the many other "paramedical" people working at poverty wage levels. Health career mobility is insignificant.

Planning, if it can be called that, is uncoordinated, piecemeal and not apparent at the service level. It is certainly not in the hands of the people, The mouthpiece of the American physician, the American Medical Association, practices through its powerful Washington lobby a kind of anti-planning by opposing whatever health legislation happens to be pending, proudly abdicating the social responsibility of the doctor "in defense of Capitalism—the American way of life," to quote last year's AMA president.

The federal government, for its part, has stepped up its activity in the health area by introducing such fragments of social policy as Medicare and Medicaid, which have had no impact



on the organization of health services, but have highlighted the disarray, inefficiency and even corruption of the American health "system." (Last year in Connecticut, for example, 85% of the state's Medicaid money went into nursing home care; only 15% was used to defray the health care costs of individuals under 21. The intent of the legislation, however, was to help poor families in the payment of medical expenses for their children, and only secondarily to provide a supplement of sorts to the Medicare program).

In addition, the government has introduced two major pieces of "health planning" legislation—the Comprehensive Health Planning Act and the Regional Medical Program Act. The intent here is to provide both the stimulus and the financing mechanisms for regional health planning and coordination, concerned with "comprehensive" health service in the case of P.L. 89-749 and the problems of heart disease, cancer, and stroke in the case of P.L. 89-239.

The problem has been that no one knows specifically what the legislation means, or even what the differences between the two pieces are; the government, in fact, has had to conduct regional "seminars" for "planners" to try to get at the separate meanings of the programs. And on the state and local levels, confusion is even more rampant: in Connecticut alone, there are twelve different health care planning agencies and programs, and sixteen different financing programs affecting health care planning.

The only reasonably clear thing about the "health system" in America is that it keeps costing more, and that the increases in prices for health services are steeper than those in the rest of the economy. This is especially true with regard to hospital service, where prices in the past twenty years have increased more than three times the consumer price index. For the thirty-five Connecticut hospitals, total costs per patient day have gone up 180% in the past ten years.

There are plenty of both real and imaginary reasons for these increases, including the general rise in prices in an inflationary economy, the increase in the number and complexity of services rendered, the increase in the number of health workers per patient, particularly skilled workers, and the rise in the wages paid to them (which today account for about 70% of the expenditure of hospital income).

Everyone complains; the hospitals parade their "huge annual deficits"; health insurance companies large and small elude the hands of accountability; doctors and drug companies keep still; the federal government never mentions that in all other western countries governments meet from 75% to 90% of their nations' health service costs.

Survival and Power

The American health service industry operates not in a system, but a jumbled marketplace. It is an expensive, technological, terribly complex marketplace in which the consumer is fairly helpless and the provider pretty much in control. Because the demand for health care and for relief from pain continues and grows, and because society has not "ordered" the transformation of the marketplace into a rational public service system, the health industry will continue to do what survival in a marketplace demands.

In the process of servicing the health needs of the people, the industry will also take advantage of those needs to maintain and enhance its own interests and profits. Not rapaciously, but quietly in the midst of the great complexity and the chanting of the healer: "I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment..."

It is not that the professionals, the providers and the deliverers of health care are malevolent materialists or unconcerned about the welfare of the American people. Like the consumers, they are trapped by the "system," by the marketplace which they created, in which they operate, and to which they have become accustomed. To survive in it, they must look after their own interests first, which are basically economic, and then perhaps to the larger needs of the people they serve.

So it is that many doctors seem so protective of their professional guild, or preoccupied with personal profit and the weekly investment column of the American Medical Association newsletter; that drug and insurance companies tend to their corporate profits; that hospitals, medical schools, and medical centers press for research dollars and raise service charges to maintain financial stability and institutional prestige. As is the case anywhere else, power in the health industry seeks to perpetuate itself.

There are, though, many components to that power, many different forces acting on it and within it. Sometimes forces within the health industry work together: as when the drug companies ingratiate themselves with the medical schools by supporting research and handing out favors to students, and the medical schools reciprocate by farming out professors to test drugs or by packing them off to Washington to testify on behalf of the activities of the large drug firms.

Sometimes the forces are not in harmony, as was the case last fall when the Connecticut State Medical Society held up action on the Connecticut Regional Medical Program's request for five-year operating funds because it felt the CRMP denied it "partnership" status with the university medical centers in the program.

The power structure in the health industry is a shifting one today; its center is not easy to define. The AMA, once the unquestioned authority in the marketplace of health, is becoming increasingly discredited in medical-economic affairs, and exerts its influence now chiefly in "clinical" medical care matters. There has been a striking growth in recent years in the importance and influence of the health middlemen, particularly Blue Cross, and in the role of the government in health affairs.

As important as all of these changes, however, has been and continues to be the expansion of the power of the country's

88 medical school-medical center complexes affiliated with about 500 hospitals. They are by no means the major source of health care in the land; there are, for instance, more than 7,000 hospitals in the United States.

But because they are the heart of medical education and health research, and because they are more and more the bastions of information and communication in health matters, the medical centers are accumulating control over the tools of power in the health industry. Their impact is felt most strongly in those towns and cities whose health resources they dominate: towns like New Haven, Connecticut, with its Yale-New Haven Medical Center.

II. The Yale-New Haven Medical Center

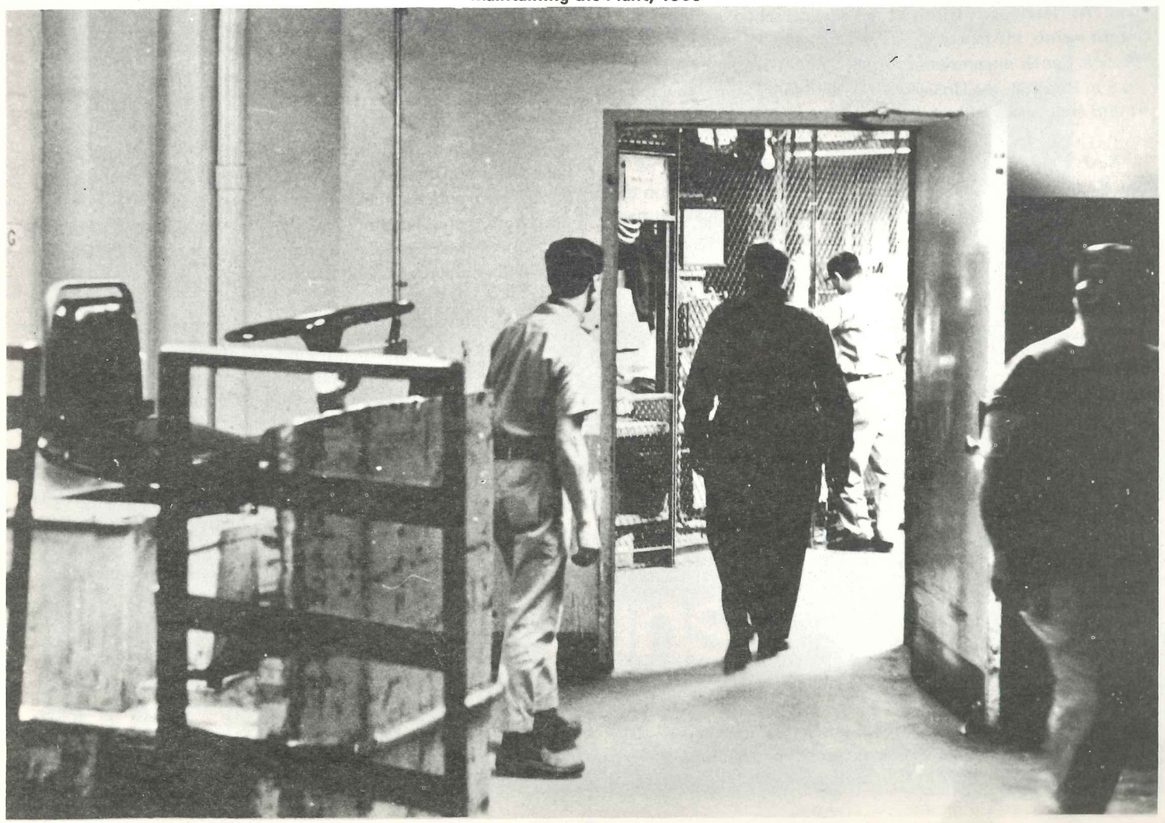
In 1810, the Connecticut General Assembly passed a bill granting a charter for the "Medical Institution of Yale College," to be conducted under the joint supervision of the College and the Connecticut State Medical Society. In 1884, the original charter was amended to place the medical school definitely in the control of Yale; by 1918 the name Yale University School of Medicine had been adopted.

Shortly after the medical shcool had been established, the state legislature in 1826 passed an "act to establish a state hospital," which led that same year to the incorporation of the General Hospital Society of Connecticut and in 1832 to the opening of the New Haven Hospital, funded by contributions from medical school professors, the state, the citizens of New Haven, and the "tax" paid by merchant sailors within the New Haven port district entitling them to free medical care.

From its inception, the New Haven Hospital, designated as a "community hospital," was used as the clinical teaching facility of the medical school; however, it was not until 1912 that this arrangement was formalized in an agreement between Yale and the Hospital. Meanwhile, in 1892, another hospital had been created in New Haven, the Grace Hospital on Chapel Street. It operated independently until 1945, when the New Haven Hospital and Grace Hospital merged to form the Grace-New Haven Community Hospital, a move designed to consolidate resources and offest some of the financial problems of the expanding hospital industry.

By 1953, the old Grace Hospital on Chapel Street had been replaced by the newly constructed Grace Memorial Unit, adjacent to the medical school and New Haven Hospital. In 1958, the relationship between the medical school and the Grace-New Haven Community Hospital was revised, and the Yale-New Haven Medical Center was formed. In 1965, because there continued to be serious problems in the working relationship between

Maintaining the Plant, 1969



the school and its teaching hospital units, another affiliation agreement was drawn up. This time, the name Grace-New Haven Community Hospital was changed to the present designation, the Yale-New Haven Hospital.

The Yale-New Haven Medical Center of 1969 is a New Haven giant, with a combined annual budget exceeding $60 million and encompassing some 6,000 people, including patients. The Yale-New Haven Hospital itself, operating on a $20 million annual budget, employs more than 2900 people (not including physicians), participates in more than 15 educational and training programs, has about 750 adult and pediatric beds, 116 bassinets and 75 outpatient specialty clinics; it is one of the several largest hospitals in the United States.

The Yale University School of Medicine operates on about $23 million a year, and is, of course, backed up by the more than half-billion dollar Yale University endowment. Schools of nursing and of public health, the Yale Psychiatric Institute, the Yale Child Study Center, and the Connecticut Mental Health Center (owned by the state and directed by professors of Yale's psychiatry department) are all components of the complex.

The land triangle of the Medical Center (bounded by South Frontage Rd.–College St.–Congress Ave.–Howard Ave.) is filled with these institutions, and with the constant clamor of new construction. Nor is the Medical Center confined to this one triangular tract on the periphery of New Haven's Hill section. As Dean F.C. Redlich of the medical school noted in a recent memo, the extremely complicated organization of the Medical Center encompasses the West Haven Veterans Administration Hospital, the University Health Service, and "now the new health enterprises in the community."

Such growth and expansion are main themes in the life of the Medical Center. The 1950's and 1960's saw, in addition to the Memorial Unit, the completion of such impressive facilities as the Laboratory of Epidemiology and Public Health, the Laboratory of Clinical Investigation, and the Hunter Radiation Therapy Center. Plans for the 1970's include a $9 million basic science research-medical science teaching facility, and a "Hospital Towers" complex to be built on the ground presently occupied by St. John the Evangelist Church and its school.

Hints are that while this latter structure will provide some of the additional beds to meet the New Haven community's growing needs, it will be geared primarily toward the scientific and technological needs of the modern Medical Center in the areas of electronic information processing and surgical transplant and cancer study. Expanded parking facilities close to the main complex are being designed, although precisely what uses the Medical Center will make of Yale's numerous, generally undisclosed holdings in the Hill area is unclear at this time.

By Whom and for Whom?

Who actually runs the Yale-New Haven Medical Center? The answer to this question is hidden in a maze of overlapping boards and committees and interlocking staff appointments; Dean Redlich himself has claimed he doesn't know who makes decisions in the Medical Center. As the accompanying analysis demonstrates in some detail, Yale University has achieved a dominant network of influence and control over the entire Medical Center complex.

Yale's control over this traditionally feudal system has solidified during Dr. Redlich's first two years as Medical School Dean. What may eventually emerge as the result of this consolidation of Medical Center power in Yale's hands is a private "government" of health care in the New Haven region—of, by, and for Yale.

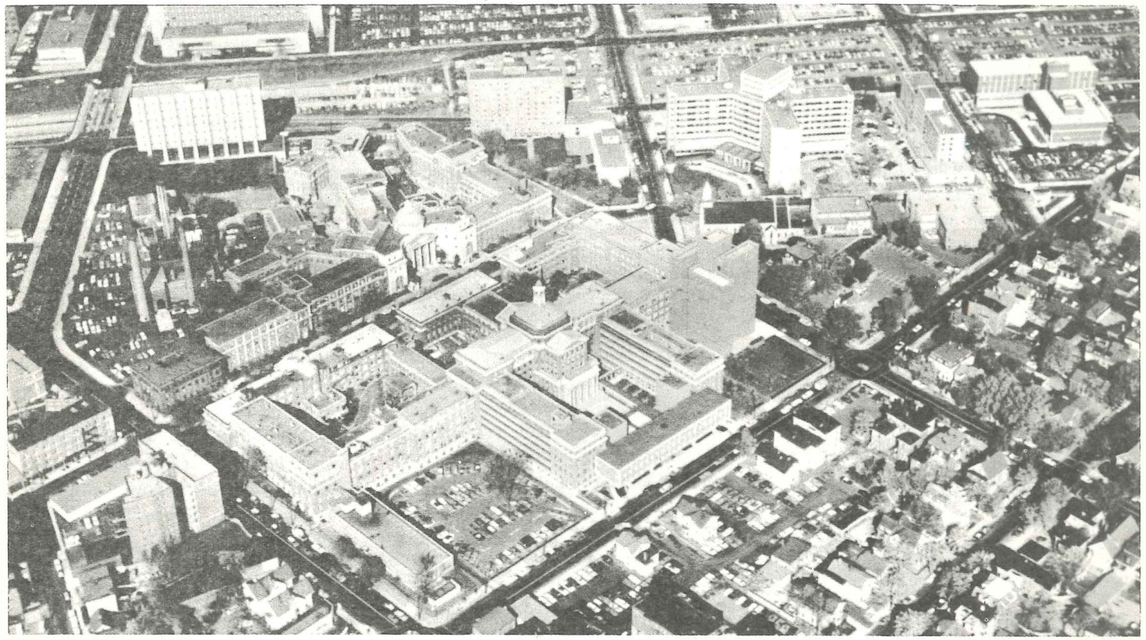
Yale's increasing control would not be very significant if the Yale-New Haven Medical Center were meeting its obligations as by far the major resource for health service in the New Haven community. When the question of community service comes up, Yale and the Medical Center like to point to the multitude of highly trained, highly skilled health scientists and specialists, and their trainees, or to the impressive variety of supertechnological facilities available to the ill and suffering of the community.

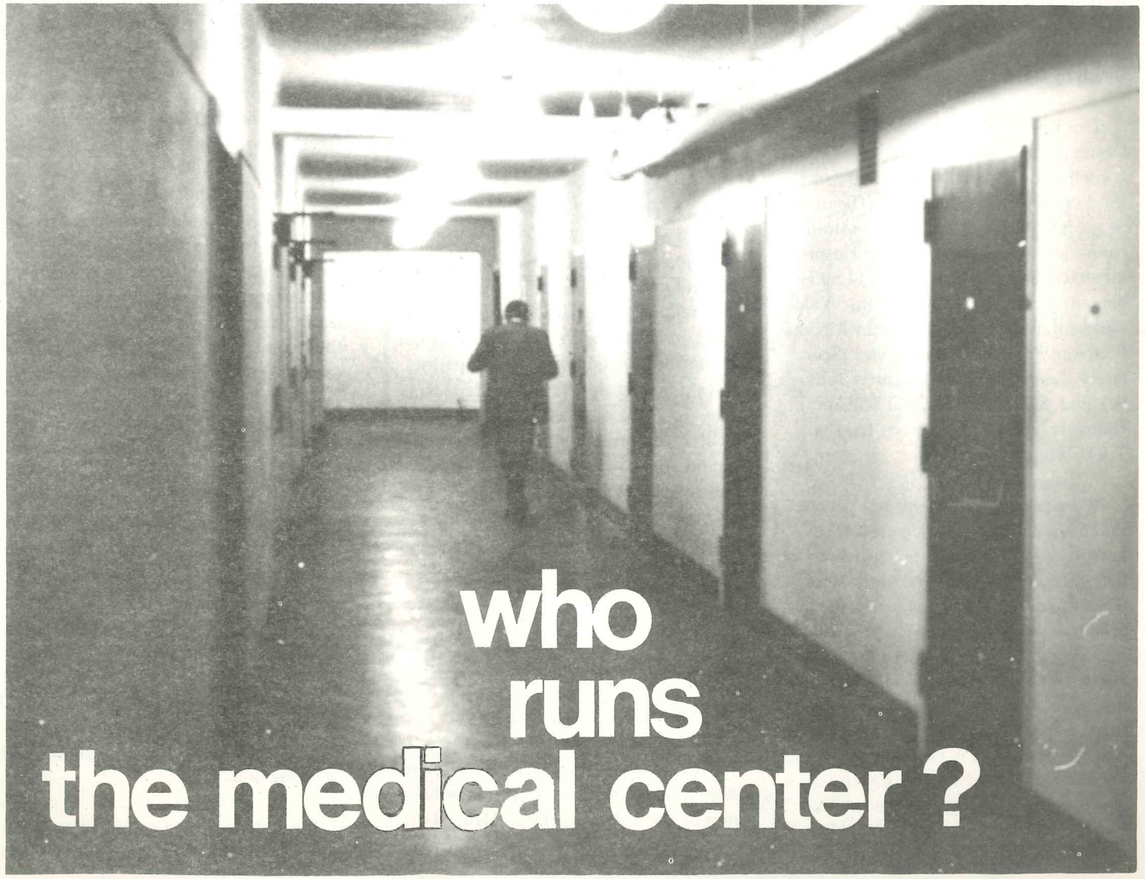
What they leave out of this demonstration is the fact that all these people, all the facilities, are trained, developed, geared or otherwise manipulated from the vantage point, and in line with the interests of corporate power—the power symbolized by the affiliations of the Yale University trustees and the Yale-New Haven Hospital Board of Directors. There is nothing mysterious about this; nothing which makes the motives or principles of Yale management of its own interests different from, say, those of Pratt & Whitney or Ford.

One group of directors deals with airplanes or automobiles; another group deals with endowment funds, research grants, and service commodities such as education and health care. But both groups want profits of one kind or another; both seek control of their respective marketplaces; both try somehow to perpetuate themselves and to expand.

The problem, then, is simple: the priorities of the corporation are not the priorities of the people; if they were, there would be no problem, only details to be worked out. The rhythm imposed by a giant institution like the Yale-New Haven Medical Center on the health care marketplace of its community is not one of service to the people first and foremost; it is a rhythm of research and teaching. These activities are the lifeblood and the motive force in the working of the Medical Center; its power, prestige and most of its income depend upon them. These are the enterprises which both serve and rule the executive boards, which determine how the market of human health needs is managed.

It is not that research and teaching are bad things in themselves; if anything, they are vitally necessary in our modern, technological society. What is wrong is that they have come to outweigh in importance the needs of the people, and that people have become the "material" which the Medical Center uses, addenda in the corporate scheme of things at the Yale-New Ha-





Who runs the Yale-New Haven Medical Center? What is the executive organization of this medical empire? Where is the power—as Dean Redlich asked so innocently in his memo introducing the latest addition to the Yale faculty, an organization analyst who will be looking at the Medical Center itself? The diagram highlights some key features. Of great importance is the fact that the two major components of the Medical Center, the Yale Medical School and the Yale-New Haven Hospital, are bound to two legally separate corporations.

The Yale University School of Medicine is a component of the Yale Corporation; the ultimate arbiters of its policies, therefore, are the trustees of that Corporation—men high in the eschelons of national business, finance and government power such as William Bundy, Will McChesney Martin, J. Richardson Dilworth, John Hay Whitney and Joseph Irwin Miller. The Yale-New Haven Hospital is not legally part of the Yale Corporation, but has independent status as a private, voluntary, non-profit hospital with its own Board of Directors.

This Board, according to the Medical Center Affiliation Agreement of 1965, is a self-perpetuating body drawing one-third of its membership from officers of the Yale Corporation and two-thirds from the community which the Hospital serves; presently, there are 24 members sitting on the hospital Board. Yale representatives include President Kingman Brewster, Provost Charles Taylor, Secretary Reuben Holden, Treasurer John Ecklund, Spencer Miller, and William Horowitz, also of the General Bank & Trust Company.

"Community representatives" on the Board are drawn from such grass-roots institutions as United Illuminating (John Betts), First New Haven National Bank (Frank Chadwich Jr.), C. Cowles and Co. (Charles Costello, President of the Board), New Haven Register (Lionel Jackson), Marlin Firearms (Frank Kenna Jr.), WAVZ Broadcasting Corp. (Daniel Kops), Plasticrete Corp. (Philip Paoella),Union and New Haven Trust Co. (William Thomson Jr.), Northwestern Mutual Life Insurance Co. (Stanley Trotman), and so on. In March 1969 the Hospital attempted to improve the image of this group by adding Henry Parker, Chairman of the city's Black Coalition. Neither Yale nor the Hospital Board is publicly accountable for what it does.

The Yale-New Haven Medical Center as such does not have a clear legal or corporate status. In essence, it is an administrative amalgam and a fancy name, an attempt to streamline and consolidate the interaction of two powerful but unwieldy institutions and their satellites.

On the one hand, the Hospital Board and the administrators who work for it are pre-eminently interested in the Hospital's financial condition, its operating efficiency, and its public image in a community dissatisfied with the quality and the cost of the service rendered by the institution. On the other hand, the medical school is concerned about its research and teaching activities, its status as an academic institution, and the utilization of a patient population as "material" for these enterprises. Since teaching and research tend to make the hospital operation less than economical and efficient, and since the use of the sick people of the community as teaching and research "material" is hardly the best thing for public relations, an essential quality of the relationship between the hospital and the medical school is conflict.

The general level of tension is further maintained by the frustrations of private community physicians, who use the Hospital, in dealing with a teaching hospital administration and by their antipathy toward Yale scientists and academicians. The "multiple missions" of the Medical Center, to borrow again from the Redlich memo, make for a great deal of administrative incompatibility, espeically when it comes down to the sticky details of defining shared goals, making faculty and hospital staff appointments, stating the relation of patients to teaching or research programs, and of medical students, interns, and residents to patient care, etc.

The Executive Boards

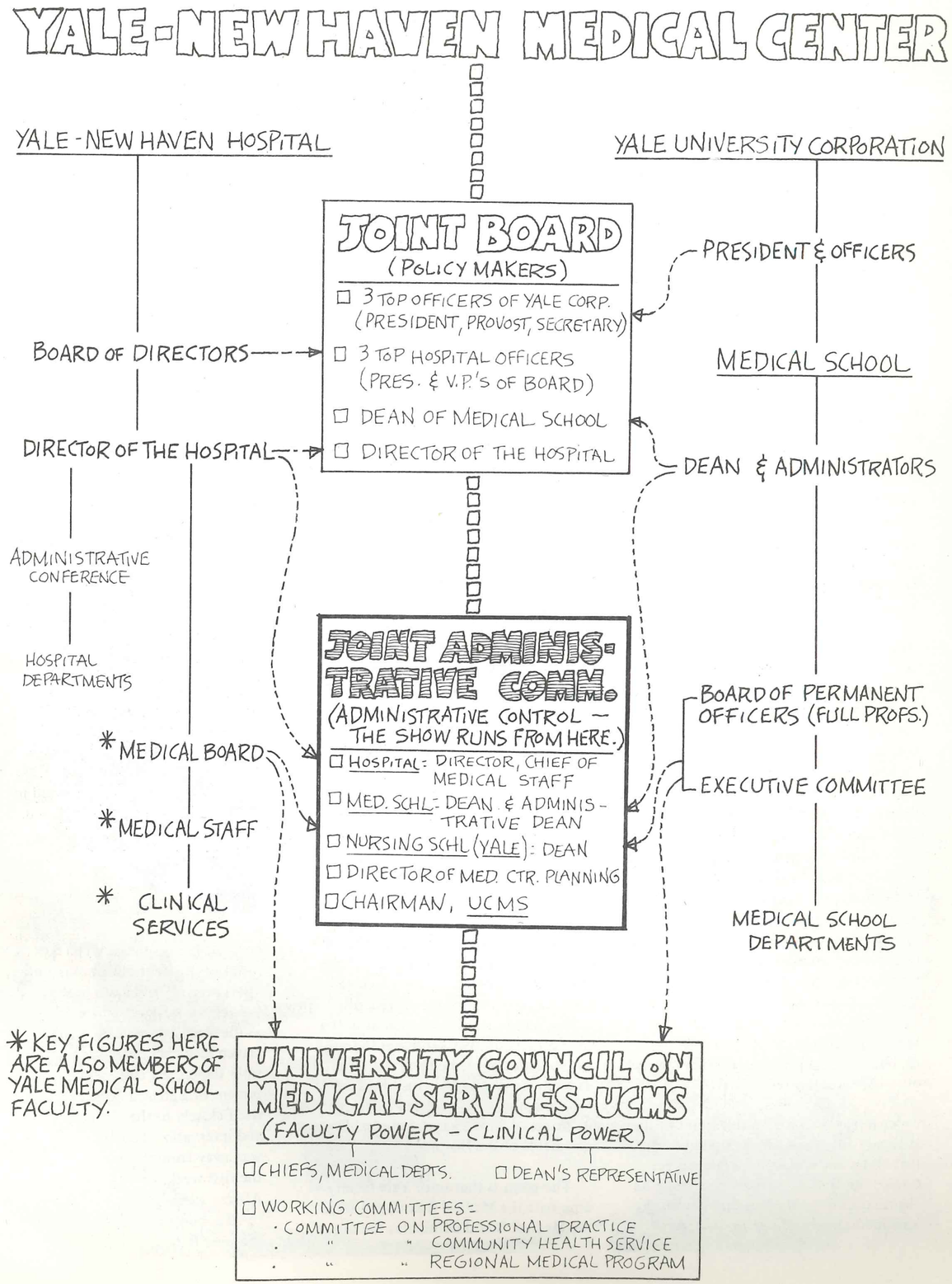
No one is really sure whether the three chief bodies constituting the organization of the Yale-New Haven Medical Center have exacerbated or relieved the conflicts within the complex of health institutions. The *Joint Board* of the Medical Center, made up of three top Yale Corporation officers, the Dean of the medical school, three top Hospital Board members and the Yale-New Haven Director, sets forth broad policies for the "Medical Center as a whole." It does not own anything; it does not rule on matters specific to the hospital such as service rates or on matters specific to the medical school such as faculty promotions.

Putting the Joint Board's policies into effect is the official job of a group called the *Joint Administrative Committee,* which often as not provides the incentives and the outlines for those policies. The "JAC" is the nucleus of real ongoing, operational power within the Medical Center. The members of this group are: the Director of the Hospital; the Chief of the Medical Staff at the Hospital; the Dean of the Medical School and his lieutenant; the Dean of Yale's nursing school; the Director of Medical Center planning; and the Chairman of the University Council on Medical Services.

These people are precisely those who monitor and control on the executive level the working of the Medical Center components, who are most in touch with its operation. The main channels of information in the Medical Center structure flow to and from these people. As a result, they bring together in the Joint Administrative Committee the organization's chief tools of power, based in the Hospital, the medical school, and the *University Council on Medical Services.*

This last group, the third major executive body of the Medical Center, consists of the chiefs of the Center's clinical departments and an Associate Dean of the medical school, the latter being the personal representative of the Dean's office within the Council. Three working committees report to the U.C.M.S.: one dealing with the conduct of professional practice in the Medical Center; one dealing with the relation of the Medical Center to the whole range of community health services; and one dealing with its role in developing various kinds of regional plans and programs.

The University Council represents the power of the faculty, a third major force


YALE-NEW HAVEN MEDICAL CENTER
YALE-NEW HAVEN HOSPITAL
YALE UNIVERSITY CORPORATION
JOINT BOARD
(POLICY MAKERS)
☐ 3 TOP OFFICERS OF YALE CORP. (PRESIDENT, PROVOST, SECRETARY)
☐ 3 TOP HOSPITAL OFFICERS (PRES. & V.P.'S OF BOARD)
☐ DEAN OF MEDICAL SCHOOL
☐ DIRECTOR OF THE HOSPITAL
PRESIDENT & OFFICERS
BOARD OF DIRECTORS
MEDICAL SCHOOL
DIRECTOR OF THE HOSPITAL
DEAN & ADMINISTRATORS
ADMINISTRATIVE CONFERENCE
HOSPITAL DEPARTMENTS
JOINT ADMINISTRATIVE COMM.
(ADMINISTRATIVE CONTROL — THE SHOW RUNS FROM HERE.)
☐ HOSPITAL: DIRECTOR, CHIEF OF MEDICAL STAFF
☐ MED. SCHL: DEAN & ADMINISTRATIVE DEAN
☐ NURSING SCHL (YALE): DEAN
☐ DIRECTOR OF MED. CTR. PLANNING
☐ CHAIRMAN, UCMS
BOARD OF PERMANENT OFFICERS (FULL PROFS.)
EXECUTIVE COMMITTEE
* MEDICAL BOARD
* MEDICAL STAFF
* CLINICAL SERVICES
MEDICAL SCHOOL DEPARTMENTS
* KEY FIGURES HERE ARE ALSO MEMBERS OF YALE MEDICAL SCHOOL FACULTY.
UNIVERSITY COUNCIL ON MEDICAL SERVICES-UCMS
(FACULTY POWER - CLINICAL POWER)
☐ CHIEFS, MEDICAL DEPTS.
☐ DEAN'S REPRESENTATIVE
☐ WORKING COMMITTEES:
· COMMITTEE ON PROFESSIONAL PRACTICE
· " " COMMUNITY HEALTH SERVICE
· " " REGIONAL MEDICAL PROGRAM

in the affairs of the Medical Center; it is dominated completely by the University's "medical patricians," the chiefs and chairmen of the specialized clinical departments and services. The "academic promoters" of an expanded social role for the Medical Center in the areas of community health services and planning, the so-called "medical progressives," merely work for and report to the University Council; they are not official members of the group. The U.C.M.S. reflects their concerns only in so far as they are compatible with the more powerful interests of the clinical chieftains and the Dean's representative.

Allegiances to Yale

The problem in trying to understand power at the Yale-New Haven Medical Center from a consideration of its structure alone is that this does not reveal, and in fact gives something of a misleading impression of, the real allegiances of many important people. The fact is that most of the key people are Yale men, receiving title, tenure, salary, status, and/or research money from and through Yale; by simple reckoning, the majority of the professional personnel at the Medical Center work for Yale.

This is obvious in the case of the medical school itself, where it is also very important to note that all of the 87 members of the *Board of Permanent Officers* (in addition to the Yale University President and Provost, and the medical school Dean) are full Yale "Professors" at the medical school. The significance of this fact is revealed in several ways: the Board of Permanent Officers is the final ruling body on major policy matters within the Yale University School of Medicine; its membership consists solely of the top-ranking medical academicians and scientists at the school; it excludes even the full "Clinical Professors" of the faculty, whose two-word titles apparently signify their other professional involvement, namely, medical practice outside the walls of the Medical Center.

With regard to the organizations of the Medical Center as such, it should be noted that all the members of the University Council on Medical Services, including its chairman and the representative from the Yale medical school Dean's office, are members of the medical school faculty; and that in the critical Joint Administrative Committee Yale clearly holds the balance of power through the Dean and Administrative Dean of the medical school, the Yale nursing Dean, the Chairman of the University Council (who is also Chairman of the medical school's Department of Internal Medicine), and the Director of Medical Center planning (who recently replaced a hospital administrator as the seventh member of the "JAC." and at the same time became an Associate Dean at the medical school).

As for the hospital representatives in the "JAC," the Chief of the Medical Staff is also Clinical Professor in the medical school's Department of Surgery; and even the lone hospital Director also has a Yale position as Lecturer in Public Health-Hospital Administration. The only executives of the Yale-New Haven Medical Center who do not have Yale University titles are the three officers of the Hospital Board who serve on the Joint Board of the Medical Center!

Finally, with regard to the Yale-New Haven Hospital itself, the full pattern of Yale power becomes clear. The most influential body in the Hospital is the sixteen-to-eighteen-member Medical Board, a group of physicians occupying key positions in the hospital medical staff, with tremendous power over patient care and at least potential control of up to ninety cents on the hospital dollar, according to one study.

The members of the Hospital Board of Directors created the Medical Board, but do not sit on it. The Dean of the School of Medicine and the Director of the hospital are members; five members are the Associate Chiefs of the hospital Departments of Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, and Dentistry, which means that although they hold Clinical Professorships in the medical school, they represent the private practice of medicine in the hospital. The remaining ten or so members are full-time, full-salaried Yale Professors in charge of all the various clinical Departments of the Hospital.

The point is that since Yale faculty dominate the Medical Board, and since the Medical Board dominates the operation of the Hospital, Yale interests are felt throughout its wards and corridors. The task of the non-M.D. hospital administration is to pick up the pieces, sort them out, and keep track of the books.

The Consequences

The net result is that through an often confusing interdigitation of titles, functions, institutional identifications, and organizational roles, Yale has achieved a network of influence and control over the Yale-New Haven Medical Center. This has become stronger in the first two years of Dr. Redlich's reign as Dean of the School of Medicine. Skillful and persuasive in the use of the tools of power, he and his small, unofficial cabinet of key advisors and administrators have begun to consolidate executive control over the traditionally feudal academic departments of the Medical School, the organization of the Medical Center, and quietly so far—the health care of the community.

What may eventually emerge as the result of this centralizaiton is a private "government" of health in the New Haven region—of, by, and for Yale. Indeed, as the Dean himself said, the Yale-New Haven Medical Center has become "possibly the biggest and most important component of a great university that relates itself closely to the local, state, national, and international community." (Redlich was away from the medical school during the first weeks of this year, travelling in Africa—seeking bases within underdeveloped countries for Yale explorations in "international health.")

ven Medical Center, where chief concerns are the research plant, the teaching factory, and the expanding domain.

So it is that Kingman Brewster writes that *"If we can contribute to the trusteeship and various levels of administrative oversight of Yale-New Haven Hospital, there is no reason, in theory, why we could not contribute to the directorship of a Yale-New Haven Development, Housing, or Education Corporation."* Or that Dean Redlich tells a gathering of medical students about the necessity for the medical school to hire scientists and doctors of national and international reputation in those fields as teachers. Or that Associate Dean Howard Levitin of the medical school attempts to correct the apparent misimpression among some students that one of the goals of the medical school is to train general and family practitioners as well as academic health scientists and clinical specialists.

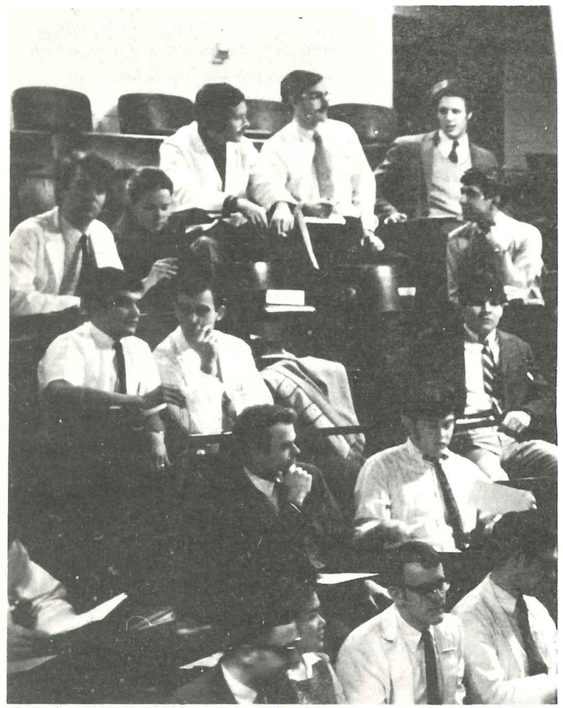
Similarly, Albert Snoke, M.D., for more than twenty years Director of Yale-New Haven Hospital, writes concerning the Connecticut Regional Medical Program that *"...a major responsibility for comprehensive health planning should be given to the teaching hospital and its administrator..."* and that *"There are distinct advantages for the university and the medical school in that there are expanded resources for referral and for teaching and in the provision of opportunities to develop or demonstrate an environmental and programmatic situation for optimum patient care to which students can be exposed and from which they can learn... ...in Connecticut, the Medical Schools, the Universities and the Teaching Hospitals feel that they have been offered, through the RMPs, an opportunity to assume basic responsibility for a necessary planning action that will affect them fundamentally..."*

Research

The best way to get an impression of the true importance of research at the Yale-New Haven Medical Center is to take a look at the financial books, in particular those of the School of Medicine. As a whole, Yale University in 1966 ranked 20th among the 100 universities in the country receiving the most federal money for research and education. It was not, however, among the top 100 universities or colleges engaged in research and development work for the Department of Defense; and in 1967 it was doing only $1.1 million worth of defense contracting—$969,000 in the New Haven area and $132,000 in Alamagordo, New Mexico. (Source: James Ridgeway, *The Closed Corporation—American Universities in Crisis;* remaining figures are from Reports of the Yale University Treasurer, 1966-67 and 1967-68).

Yale has relied, rather, on the annual supply of funds to the medical school from the United States Public Health Service

Waiting too Long for too Little



for its "big chunk" of Federal research money. Thus, for 1966-67, of the $23.9 million Yale received in federal research grants, $11.1 million was USPHS money going to the Medical School; for 1967-68, comparable figures were $26.8 million and $13.9 million.

The medical school, for its part, relies on these USPHS grants, with their comfortable overhead allowances of from 5% to 50%, for the better part of its annual operating income; combined with other gifts and grants from various federal agenices, private research foundations, drug companies, etc., monies for "research and sponsored activity" amounted to 68% of total operating income in 1966-67 ($13.3 million out of $19.3 million) and 71% in 1967-68 ($16.3 million out of $23.0 million).

This percentage is likely to increase in the future, in spite of the widespread fear of federal grant cutbacks: two of the important reasons being that income from tuition at the medical school, in spite of regular increases, accounts for only a small, fairly stable four per cent of the budget; and income from specific medical school endowment, also small, is not expanding substantially. In fact, the medical school's contribution to the total Yale endowment fund has dropped in the past two years: from $28.2 million to $27.7 million, although the Yale University total has been doing well (valued now at about $560 million, second only to Harvard) since the Yale Corporation created the Endowment Management and Research Corporation, located in Boston, to manage its investments.

The value of this great research enterprise to Yale and the Medical Center is not measured simply in mundane economic and financial terms, however. There are, too, those less easily defined rewards of institutional prestige, national and international corporate "glamour," and academic power. Now and then there are unpleasant moments, such as when the *New Republic* magazine accused Yale of conducting chemical and biological warfare studies under the cover of "basic immunological research." But by and large the impression carried forward is one of a great university institution advancing the frontiers of science and training tomorrow's medical leaders, thereby serving humanity.

Teaching

The conduct of medical education at the Yale-New Haven Medical Center is interesting. Although they are a minority of the students and trainees in the medical complex, the 400 or so medical students are the focus of educational attention—and rightly so, since they are being trained as the prime deliverers, the ones who will be giving the orders to and making use of those other personnel such as nurses, aides, technicians, etc.

These days, too, there are more orders to give; since 1900, for example, while the number of doctors has grown 58%, the number of nurses has climbed 4,000%! Even today, the AMA maintains an effective Washington lobby opposing the involvement of medical education in the general federal subsidization of graduate professional education. The grounds for the opposition have been the perogatives of the guild; the results have been a shortage of doctors, an almost total lack of funds for poor and black students hoping to study medicine, and a profession dominated by the upper class.

Well over half of the medical students at Yale, as elsewhere, are sons or daughters of professional and managerial families. Their teachers are the patricians of the medical profession, the professors who research and specialize. The initial findings of one study of the "teaching physician" disclosed that although none of the faculty think the trend should be encouraged, 50% believe that medical school does shift the student view of "patients as people" to one of "patients as diseases." Only 26% would most like to care for patients and research problems involved in their care; the rest place a greater priority on research-the-thing-in-itself.

In rating students, faculty consider those going into academic careers above average 57% of the time, those going into specialized practice above average 13% of the time, and those going into general practice above average, well, 1.5% of the time. There are differences in the feelings of part-time and full-time faculty on matters like these, but of uncertain significance.

In any case, the medical students quickly learn about the priorities of their first teachers, who are not doctors really but "basic scientists," and about the priorities of the Yale Medical School, which hands them during their first few weeks in New Haven an outline of the requirements and procedures for a thesis of "scientific interest and merit" to be completed before graduation some four years ahead.

Perhaps the most difficult time for the medical students comes when they begin their first intensive clinical experiences, when they at last begin to deal with the things they have been reading about, with people. Dressed in their white coats, stethoscopes pocketed and ready, they listen and watch as one of Yale's master clinicians begins: "Mr. X has kindly consented to let us use his chest for the hour..." Tap, tap, tap. Or: "This kind of reflex hammer you can't get outside of Europe. The handle is made of oriental bamboo..." The patient, ten days into a paralyzing stroke, unable to speak and unable to move, groans as the doctor tests his reflexes.

These are shocking experiences, perhaps deliberately so. Students bury them somewhere, pass the National Board Examinations, go on the wards. By this time, they are far too busy with duties and responsibilities to contemplate for very long the human, personal meanings of the things going on all around them. On most of the teaching hospital's wards, their performance is essential, from the "scutwork" they learn to distaste to the work involved in dealing with the medically more challenging "interesting case." By being essential when they are not quite trained for it, by watching and listening to their Yale mentors, the students in these clinical years are shaped for the obligations of their "sacred trust."

Unknown Facts

One of the very strange things about a booklet put out by the Yale-New Haven Hospital entitled "Information for Patients," in a section called "At Your Service," is the absence of any reference to medical students. Literally every other possible sort of person is mentioned who could do anything for a patient, from doctors and nurses to painters, plumbers and librarians. But no mention of the medical student, or the clause in the Medical Center Affiliation Agreement specifying which class of patients he may learn on, and which class he may not.

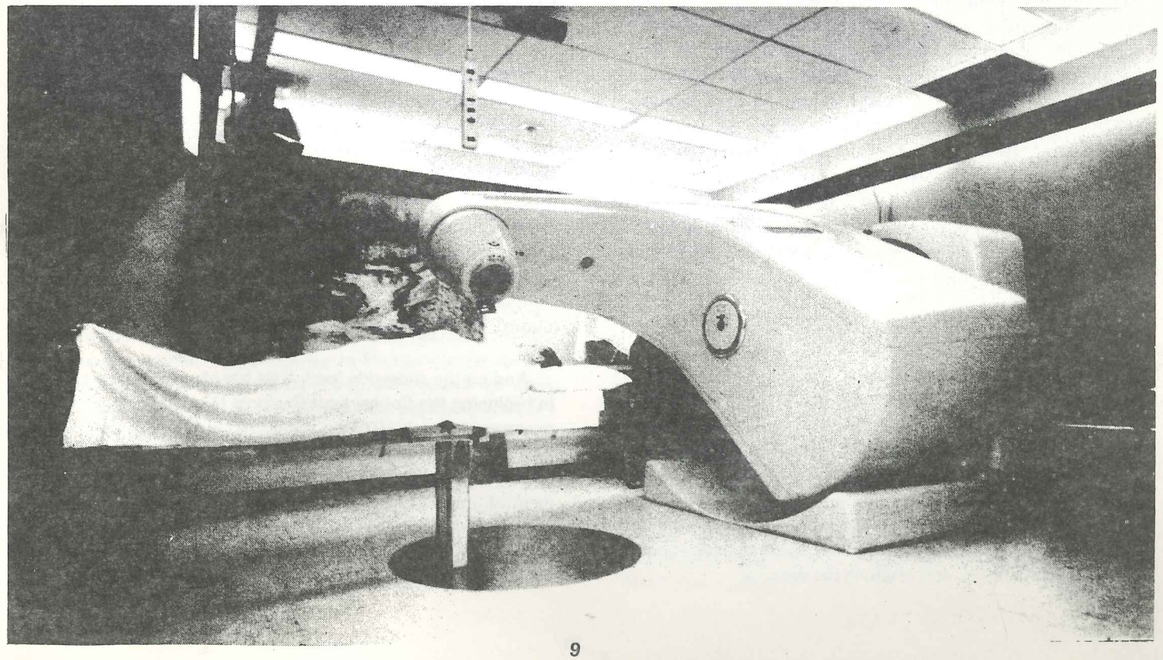
No mention either of the fact that according to one study of "teaching hospitals" as many as half of the purchase orders in a hospital like Yale-New Haven are for research-related activities; or that room rates and service charges are higher at Yale-New Haven than at other general hospitals in the area. Nothing said about the fact that the patient's doctor, if he happened to be on Yale's full-time clinical faculty, netted along with his colleagues something like $1.7 million last year in doctor's bills, collected through the medical school's Office of Professional Services, and used for research.

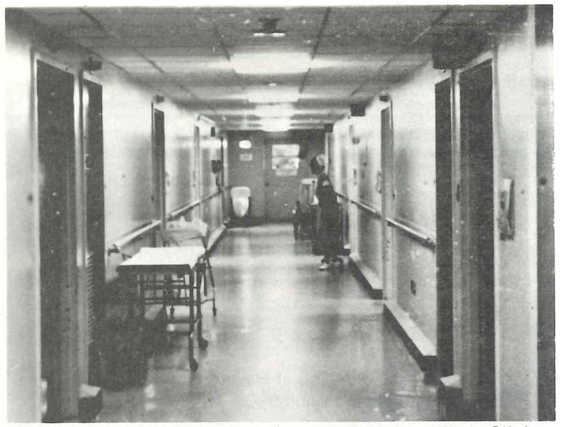
No mention of the findings of Raymond Duff, M.D., a Yale pediatrician, and August Hollingshead, Ph.D., a Yale sociologist, published after seven years of research as *Sickness and Society,* which document the high degree of ineffectiveness, inefficiency and inequity in the area of patient care at Yale-New Haven Hospital.

No mention of Dean Redlich's immortal introduction to *Sickness and Society: "...I do not agree with all their answers, and I do not agree with some of their implicit assumptions. It is impossible for me to accept the fact that medical teaching and research are not compatible with good medical care. I do not believe that an inherent antagonism exists among physicians, hospital administrators, and nurses or that hospitals are run for the benefit of physicians..."*

But the facts are there, recorded by Duff and Hollingshead. Whatever the prestigious institutional disguises used to cover them up, they remain as clear as the difference between the private suites of the Memorial Unit and the public service wards of the

...six-million-electron-volt linear radiation therapy accelerators for all...





old New Haven Unit, between the posh and private Dana Clinic and the wellworn Outpatient Departments: there are classes of people, classes of patients, classes of care at the Yale-New Haven Medical Center. They exist because the Institution exists, devoted to research and an unenlightening sort of teaching, in a class society.

Poor people, people without a private physician to refer them, even people who live comfortably but do not have the resources to cover big health bills, enter the Yale-New Haven Hospital not just as sick patients, but as teaching material and "interesting cases," to be studied and used by the unmentioned medical students, physicians-in-training, and ubiquitous researchers. They cannot be turned away from the crowded emergency room, the clinics or the wards; there is no place else for them to go.

The hospital administrators, on behalf of the financial solvency and the stability of the Medical Center, accept the challenge of these patients, wrestling with social security or welfare agencies for reimbursement, going to court for larger fees from the state. Those who can pay, from their own pocketbooks or through their insurance, pay dearly for their privacy, their doctors, their hospital services. By satisfying them, the hospital hopes it can cover at least in part some of the bad debts and accounts receivable generated by the poor. It's the same medical marketplace found all over the country, modernized in keeping with the mission of the Medical Center: to provide Intensive Care Units and six-million-electron-volt linear radiation therapy accelerators for all.

III. The Rhetoric of Change

In recent years, some of the people of New Haven have begun to make public their dissatisfactions with the often vulgar exploitation of the community by the Yale-New Haven Medical Center. This is particularly true of the Hill section of town, the inner city community which surrounds the institutional complex, and from which Yale and the hospital draw a good many of their laborers and teaching patients.

The militant Hill Parents Association, the group most in touch with the anger and the impatience of black people, has spoken out about the criminal negligence of community needs at Yale-New Haven; the activation of the Hill Health Board-Hill Health Council as a component of the newly formed Hill Neighborhood Corporation, the city's community-run Model Cities agency, has set in motion the representation of community health interests in a variety of ways still in the beginning stages.

The implications of such gradually emerging changes in the attitudes of the consumer community and in their demands for decent health care have not been lost on either Yale or the Medical Center. Sensing the growing unrest of the community, Yale has quickly, and so far adeptly, put into play the most contemporary tool of power, the "social responsibility" gambit, to soothe the potentially disruptive social forces surrounding it, and to further maintain and enhance its own interests.

The payoffs are tremendous: the anger of the people is cooled by the illusion of Yale concern and involvement; a convenient liberal rationale is provided for Yale-based enterprises and expansion plans; and the institution is guaranteed, through nothing more than the skillful application of rhetoric and prestige, a fine new source of funds for research, construction, administration, recruitment, paying its faculty, etc.—the government "social program" grant.

Employing the skills of several medical progressives on the periphery of power, the Medical Center has proceeded to refurbish the Hospital Emergency Room and ambulatory service facilities, and has been experimenting with a model Family Health Care Program. The hospital has hired its first "patient advocate," selected and trained by the Dixwell Legal Rights Association, which for the time being at least gets the money for the position from the hospital; whether or not this sort of advocacy position has much effectiveness or value, it hasn't hurt public relations.

Reaching out to the community, Yale has funded through HEW's Children's Bureau the spanking new Hill Health Center, a comprehensive care facility whose three health teams have just recently begun to take care of children in the Hill section, and which plans eventually to expand and provide adult health care services. From the offices of the Medical Center, a comprehensive prepaid industrial-labor-community health care program in New Haven, promoted initially by the city's Central Labor Council, is being developed. Plans are also underway to create a comprehensive health program for another New Haven community, the 'Yale family'.

And on the statewide level, Yale has played a major role in beginning the Connecticut Regional Medical Program, whose operation through 1973 is summarized in the titles of its "seven thrusts:" I) Planning for efficiency and continuity of patient care in the ten sub-regions of Connecticut; II) The development of university-community hospital partnerships; III) The provision of selected specialized hospital services; IV) The development of selected programs of education for the health professions; V) Research and evaluation in the developing Connecticut medical care system; VI) Special considerations in financing health care; VII) Core staff to implement and evaluate the beginning operating program and to continue planning for the optimum Regional Medical Program for Connecticut.

What all this means is that the CRMP plans to organize major health care areas and resources to fit the specialized capabilities which the university medical centers (Yale in New Haven and the University of Connecticut in Hartford) control. The Director of the CRMP, Dr. Henry Clark Jr., is a professor at both Yale and the University of Connecticut. More importantly, Yale controls the purse strings; familiar names dot the accompanying grant application for $23.9 million (of which about $6.3 million has been approved to date).

Corporate Wisdom

Behind all these developments is the wisdom of the corporation. John Thompson, Professor of Public Health (Hospital Administration), key advisor to Dean Redlich, recently made Associate Dean for planning at the medical school and appointed to the Joint Administrative Committee of the Medical Center as Director of Planning, in addition to being Associate Director of Planning at Yale-New Haven Hospital and sometime "student" of people's health needs and demands, described the situation in an interview: the past few years have seen dramatic changes in the community-medical center relationship, changes which most universities have been slow to comprehend, perhaps because of the absence of reasonable models for the social role of the modern medical center. On the one hand, there is the notion of the "pathological museum with gatekeepers" exemplified by the medical complexes at the University of Florida and the University of Connecticut, and proposed for Newark, New Jersey, until the black community threatened to burn. Yale has been prevented, in some respects, from developing along the "pathological museum" track because it is the primary community health service in the New Haven area; it simply cannot close its doors to consumers and their health needs. The problem today is finding a solution compatible with the interests of the powerful clinical chiefs, the demands of research and teaching, and the demands of both the ghetto and the general consumer of health services.

Because, Thompson claims (on the basis of either incorrect facts or a strong fear of future developments), people in New Haven now have the option, through federal financing programs, of getting primary care at either the Yale-New Haven Medical Center or the offices of private practitioners, Yale has to think seriously about maintaining a patient input or losing its teaching-research material. This is the key to Medical Center development—formulating ways to supply the future material-manpower needs of the teaching-research institution by providing service to the material-manpower population acceptable to them. It thus becomes necessary to make the delivery of health services at Yale-New Haven Hospital more attractive, to build up Hill Health Center types of facilities which have ties to Yale, to back up comprehensive health care services such as the prepaid industrial-labor-community program, again with ties to Yale, and to find new populations as the "Yale University Family."

Dr. E. Richard Weinerman, noted Yale Professor of Medicine and Public Health, reinforces these conclusions, writing about "Social demands upon the health care delivery system—the response of the university medical center": *"...opportunity now exists to exploit fully the academic potential of the three-ring complex of community-based and university-affiliated health services....as the new group practice centers are completed and the affiliations with outlying community hospitals are developed through the Regional Medical Program, the network of resources for an enriched graduate training experience will be available."*

Clearly, the maintenance of institutional power and prestige requires these days a flexible response to changing social demands, and an expansion program in line with the new moods and needs of society. Yesterday's exploitation becomes forward-looking social responsibility, and the game goes on.

The Regional Medical Program Grant Application: Planning for Yale control of statewide medical care?

Form Approved; Budget Bureau No. 68-R932

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

APPLICATION FOR
REGIONAL MEDICAL PROGRAM GRANT
(HEART DISEASE, CANCER, STROKE, AND RELATED DISEASES)

LEAVE BLANK (FOR NIH OFFICE USE ONLY)
TYPE | PROGRAM | APPLICATION NUMBER
REVIEW GROUP | COUNCIL (Month and Year)
REGIONAL MEDICAL PROGRAMS
DATE RECEIVED

1. DESCRIPTIVE NAME OF PROPOSED REGION (Do not exceed 53 typewriter spaces)
The State of Connecticut

2. TYPE OF APPLICATION (Check one box EACH in A and B) → A. ☐ PLANNING ☒ OPERATIONAL; B. ☒ New ☐ Continuation ☐ Supplement

3. PROGRAM PERIOD (Not to exceed June 30, 1969): From July 1, 1968 Through June 30, 1973
4. TOTAL AMOUNT REQUESTED IN ITEM 3: $ 23,936,091
5. AMOUNT REQUESTED FOR FIRST 12-MONTH PERIOD: $ 3,696,657

6. APPLICANT ORGANIZATION (Name and Address - Street, City, State, Zip Code) A SINGLE APPLICANT ORGANIZATION SHOULD BE LISTED (See Instructions)
Yale University School of Medicine
333 Cedar Street
New Haven, Conn. 06510

7. TYPE OF APPLICANT ORGANIZATION
School of Medicine

8. NAME OF PROGRAM COORDINATOR (Last, first, initial)
Clark, Henry T. Jr., M.D.

9. MAILING ADDRESS OF PROGRAM COORDINATOR (Street, City, State, Zip Code)
Conn. Regional Medical Program
272 George Street
New Haven, Conn. 06510

10. ORGANIZATIONAL AFFILIATION AND POSITION TITLE
Program Coordinator, Conn. Regional Med. Program
Visiting Prof., Public Health - Yale Univ.
Visiting Prof.; General Medicine - U. of Conn.

11. AREA CODE: 203 | TELEPHONE NUMBER(S): 776-6872 and 776-2085

12. NAME AND TITLE OF OFFICIAL AUTHORIZED TO SIGN FOR APPLICANT ORGANIZATION
F. C. Redlich, M.D.
Dean, Yale University School of Medicine
333 Cedar Street, New Haven, Conn.
562-1151, Ext. 753

13. NAME, TITLE AND ADDRESS OF OFFICIAL TO WHOM CHECKS SHOULD BE MAILED
Spencer F. Miller, Associate Treasurer
Woodbridge Hall
Yale University
New Haven, Connecticut

14. NAME OF RESPONSIBLE FINANCIAL OFFICER AND ADDRESS WHERE ACCOUNTING RECORDS WILL BE MAINTAINED
Patrick W. Moore, Assistant Comptroller
Yale University
451 College Street
New Haven, Connecticut

15. TERMS AND CONDITIONS - The undersigned accept, as to any grant awarded, the obligation to comply with Public Health Service Regulations, terms and policies applicable at the time of award. The undersigned further assures that: (a) Federal funds will be used only for purposes for which awarded and in accordance with the applicable provisions and regulations; (b) The applicant institution will provide fiscal control and accounting procedures as required by the program guidelines for Regional Medical Programs; (c) The applicant institution will make such reports as required by the Division of Regional Medical Programs; (d) The applicant institution has designated an advisory group as required by the Division of Regional Medical Programs program guidelines, and has included particulars concerning such group in this application; (e) Any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant will be paid wages at rates not less than those prevailing on similar construction in the locality. The undersigned agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), and the Regulation issued pursuant thereto and state that our formally filed Assurance of Compliance with such Regulation (Form HEW-441) applies to all participating institutions. The undersigned also certify that they have no commitments or obligations, including those with respect to inventions, inconsistent with compliance with such Regulations, and Title IX of Public Law 89-239.

16. SIGNATURES (Signatures required on original copy only) (Use ink. "Per" signatures not acceptable)
A. SIGNATURE OF PERSON NAMED IN ITEM 8: Henry T Clark Jr M.D. — DATE: March 1, 1968
B. SIGNATURE OF PERSON NAMED IN ITEM 12: F.C. Redlich (M.D.) — DATE: February 26, 1968

NIH-925-1
Rev. 5-66

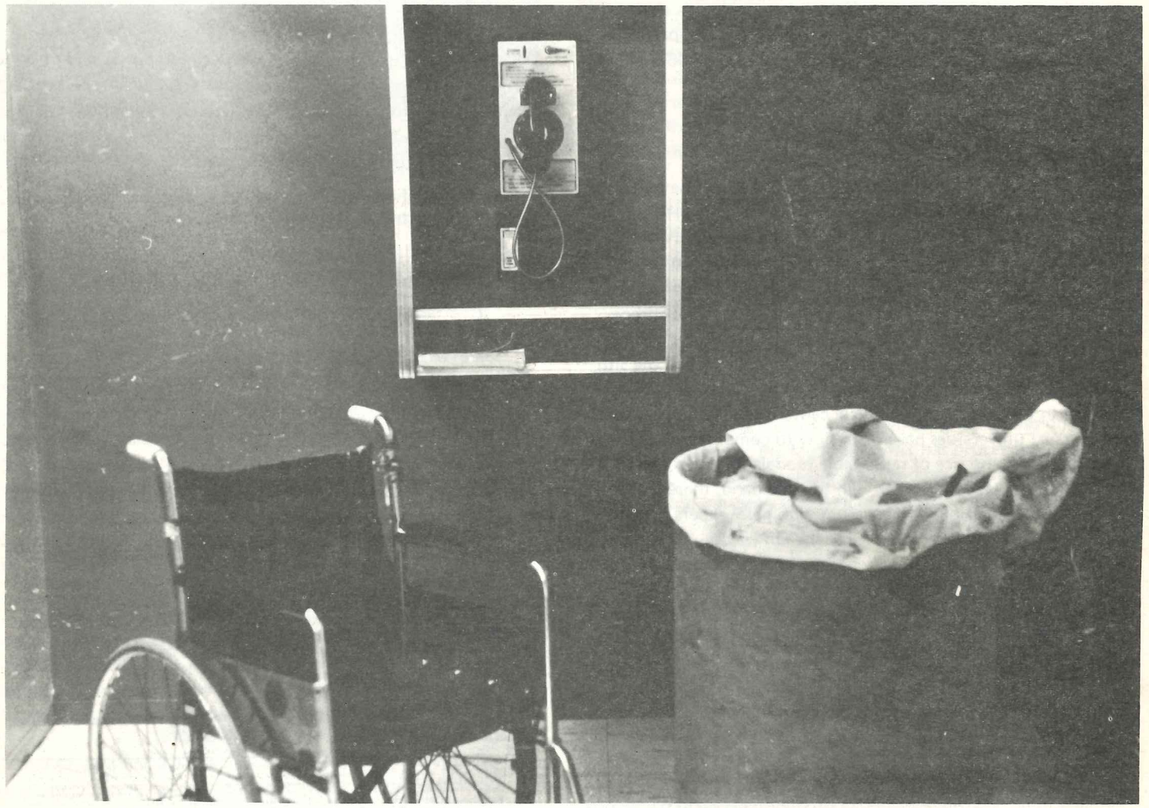
IV. Toward Real Change

Toward change—toward the transformation of the health care marketplace and the medical empire into an effective public service. Toward a "health system" that serves the people's needs, that responds to them and not the unaccountable boards of trustees, administrators, specialists and scientists. Toward human service, and not the service of famous institutions or closed corporations.

Power is the problem, in health as elsewhere; and power, whether expressed in vast sums of money or sprawling technological organizations is what the people do not have. It begins with organizing—blocks, neighborhoods, communities; it proceeds to battle. Battle here to get majority control of the Yale-New Haven Medical Center Housing and Development Corporation, Inc.; battle there to keep a third-rate convalescent home off of the community's valuable land.

Battle tomorrow for effective mechanisms of consumer health care review and for community control of the Hospital Board, the Medical Center Board, the Health Department Board, the Regional Medical Program Board. Use the tools of politics, and the tools of the professionals.

It has begun slowly, the struggle for public accountability and community control in health services. It will be a long struggle, like many others and one with them, "a journey of a thousand years." The enemies are strong, arrayed on every front, wielding the power and mythology of many years.



ABOUT THIS ISSUE

Richard Katzman is a second year medical student at Yale. He is also active in AIM.

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